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IN THE
SUPREME COURT OF THE UNITED STATES
October Term, 1997

CHARLES SHEPHARD,
Petitioner

Versus

PROVIDENT LIFE & ACCIDENTAL INSURANCE COMPANY

On Petition for Writ of Certiorari
To the United States Court of Appeals
For the Ninth Circuit
No. 95-56664

PETITION FOR WRIT OF CERTIORARI

CHARLIE SHEPHARD
Petitioner in Pro Se
P. O. Box 521
Ontario, CA 91762
(909) 391-3879

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QUESTIONS PRESENTED FOR REVIEW

1. The fundamental question presented for review by this case is whether or not the United States Court of Appeals for the Ninth Circuit has issued a decision in direct conflict with long-standing precedent of this court by virtue of the manner in which the Ninth Circuit went about analyzing and resolving the question of whether or not an underlying District Court Decision should be enforced or vacated?
2. The case presents the corresponding question for review as to whether or not the United States Court of Appeals for the Ninth District, under the guise of determining whether or not the District Court "exceeded its authority in granting Summary Judgment to defendant, and thereby usurped the authority of the District Court?
3. This case also presents for review the question whether or not a Federal Court should, in considering the question of whether to affirm or vacate a judgment arising out of defendant's motion for

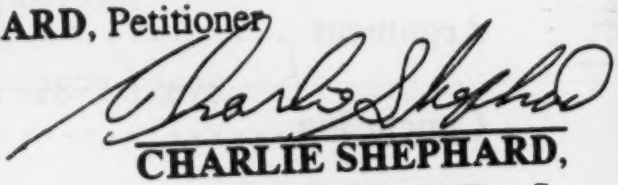
summary judgment indulge in extensive analysis of plaintiff claim of breach of contract, including the contracted provisions involved in the underlying contract, or whether the Court should in fact limit its analysis to a consideration of the question of whether the judgment "draws its essence" from the statements made by defendant's motion for summary judgment, and limit its contractual review to only defendant's statements which alleges no breach of contract or injury to plaintiff?

LIST OF ALL PARTIES

The undersigned counsel of record certifies that the following listed parties have an interest in the outcome of this case. These representations are made in order that the Judges of this Court may evaluate possible disqualification or recusal.

PROVIDENT LIFE & ACCIDENT INSURANCE COMPANY, Respondent

CHARLIE SHEPHARD, Petitioner



CHARLIE SHEPHARD,
Petitioner in Pro Se

TABLE OF CONTENTS

Page

Question Presented for Review i

List of All Parties iii

List of Authorities v

Statement of Jurisdiction 2

Applicable Statutes 3

Statement of the Case 4

Argument 6

Conclusion 29

List of Appendix 31

LIST OF AUTHORITIES

STATUTES **PAGE**

Contract Clause, Art. I, Subsection 10, CL.I 3

Due Process Clause of the Fourteenth Amendment 3

Equal Protection Clause of the Fourteenth Amendment 3

Insurance Code Section 10199-1

Insurance Code Section 12672-12675

CASES

Kouba v. Allstate Ins. Co. CHE AS 523 F. Supp 148 (1891)

Tenzer v. Superscope, Inc. Cite AS 216 Cal; Rptr 130 (Cal. 1985)

Jones v. Union Pacific R.R. 968 f. 2d 937, 940 (9th Cir. 1992)

Celotex Corp. 477 U.S. at 32, 106 S. Ct. at 2552, 91 L. Ed. 2d at 273

Egan v. Mutual of Omaha Ins. Co. (1969) 24 C3d 809, 819, 169 Cr 691, 696

Fletcher v. Western National Life Ins. Co. (1970) 10 Cal. App. 3d 376, 394 C89 Cal. Rprt. 78, 47 A.L.R. 3d 286

National Mutual Insurance Company v. Henry Garrad Clay, 82-536, 82-917

McCormick v. Sentinel Life Ins. Co. (1984) 153 Cal. App. 3d 1030, 200 Cal Rptr 732

Gruenberg v. Aetna Ins. Co. (1973) 9 C3d 566, 573, 108 CR 480, 485

Comunale v. Traders & General Insurance Co., Supra, 50 C2d at 654, 659, 663, 328 P2d at 200, 201, 203

Crisci v. Security Ins. Co., Supra, 66C3d at 429-430, 58 CR at 16-17

Silberg v. California Life Ins. Co. (1974) 11 C3d 452, 464, 113 CR 711, 718

Neal v. Farmers Ins. Exch. (1978) 21 C3d 910, 921, 148 CR 389, 395, Ln.5

Spindle v. Travelers Ins. Co. (1977) 66 CA3d 951, 958-959, 136 CR 404, 408

Bodenhamer v. Sup. Ct. (St. Paul Fire & Marine) (1987) 1912 CA3d 1472, 1478-1479, 238 CR 177, 180-181

Larraburu Bros., Inc. v. Royal Indem. Co. (9th Cir. 1979) 604 F2d 1208, 1215

McLaughlin v. Connecticut Gen. Life Ins. Co. (ND CA 1983) 565 F. Supp. 434, 451

Johansen v. California State Auto. Ass'n (Inter-Ins. Bureau (1975) 15 Cal. 3d9, 14-16, 123 Cal. Rptr. 288, 538 P.2d 744

Brown v. Guarantee Ins. Co. (1957) 155 Cal. App 2d 679, 682, 319 P2d 69

Garner v. American Mut. Liab. Ins. Co. (1973) 31 Cal. App3d 843, 107 Cal Rptr 604

Jacob R. Anderson v. Continental Insurance Co. No. 76-242, 271 North Western Rptr 2d Series 85 Pg. 368

LIST OF OPINIONS

1. Decision issued on June 19, 1996 in Charlie Shephard vs. Provident Life & Accident Insurance Co., No. 95-56664 in the United States Court of Appeals for the Ninth Circuit. (See Appendix 1)
2. Order denying Petition for Rehearing issued on June 10, 1997, in Charlie Shephard vs. Provident Life & Accident Insurance Co., No. 95-56664 in the United States Court of Appeals for the Ninth Circuit. (See Appendix 2)
3. Final Order issued by Judge George H. King on October 20, 1995, Charlie Shephard vs. Provident Life & Accident Insurance Company, Civil Action No. CV 95-0493 GHK(EX) in the United States District Court for the Southern District of California, Los Angeles Division. (See Appendix 3)

STATEMENT OF JURISDICTION

This case seeks the review of a Decision of the United States Court of Appeals for the Ninth Circuit entered on June 19, 1996. The Petitioner filed a timely petition for Rehearing, which Petition was denied on June 10, 1997. The underlying lawsuit was originally instituted in the United States District Court for the Southern District of California, under the auspices of the Contract Clause and Equal Protection Clauses of the Fourteenth Amendment. This being a case instituted under the Contract Clause and Equal Protection Clauses of the Fourteenth Amendment, seeking to recover damages for breach of contract, it is one over which the Federal Courts have jurisdiction in the first instance, and over which this Court has jurisdiction to review by Writ of Certiorari.

APPLICABLE STATUTES

1. The Equal Protection Clause of the Fourteenth Amendment of the Constitution.
2. The Due Process Clause of the Fourteenth Amendment of the Constitution.
3. The Contract Clause, Art. I, Subsection 10, Cl. 1 of the Constitution.

STATEMENT OF THE CASE

On December 23, 1994, Appellant Charlie Shephard commenced an action against Provident in the Superior Court of the State of California, in and for the County of San Bernardino, entitled Charlie Shephard v. Provident Life & Accident Insurance Company, and DOES 1 through 100, inclusive, Case No. RCV 12875, by filing a Summons and Complaint, alleging that Provident had breached its implied covenant of good faith and fair dealing with appellant, fraud, and intentional infliction of mental distress.

On January 25, 1995, Appellee filed a notice of removal of appellant's civil action from the Superior Court of the State of California to the United States District Court for the Central District of California, under 28 U.S.C. Subsection 84(c) and 1441(a).

On September 22, 1995, appellee moved for summary judgment on appellant's complaint. On October 2, 1995, appellant filed an opposition to Provident's motion for summary judgment. After purportedly considering appellee's memorandum in support of its

motion for summary judgment, and appellant's opposition to appellee's motion, the District Court on October 20, 1995 granted Provident's motion for summary judgment.

On October 30, 1995, appellant filed a timely notice of appeal, of the District Court's granting of summary judgment for Provident.

ARGUMENT

Any basic review of Federal Contract law, and of the many decisions of the Federal Courts, including this Court, on the issue, should lead one to the conclusion that there can be no question but that Provident (appellee) breached its contract, thus paving the way for plaintiff damages for its breach. The Court has no need to address the arguments concerning the alleged tortious breach of the insurance contract, a triable issue exist as to plaintiff's rights to contract damages. Hence, the summary judgment motion should have been denied. **Kouba** v. **Allstate Insurance Co.** Cite AS 523 F. Supp 148 (1981). Facts - title VII suit was brought alleging unequal pay of make and female sales agents performing equal work for Defendant Insurer. Motion for summary judgment was filed. The District Court, Karlton, J, held that: (1) employer has burden of production and burden of persuasion on affirmative defenses of Equal Pay Act; (2) Although monthly minimum for field agents merely represented a floor, it was a "wage" for purpose of Equal Pay Act. Partial summary judgment

for Plaintiff. Civil Rights 43 - Allocation of burden of proof in a title VII suit alleging unequal pay for unequal work is an issue of substantive law. Federal Civil Procedure - 2470 1 - in title VII cases, like al summary judgment motions. the court's task is the discovery of material disputes of fact, not their resolution. Federal Civil Procedure - 2470 1 - for summary Judgment Purposes a "Material Fact" is one that makes a difference in the litigation.

Conclusion – For all of the above reasons, I have determined that Plaintiff is entitled to summary Judgment on Liability. Of course, the Prop?? are left to litigate the issue of damages…

IT IS SO ORDERED.

McCormick v. Sentinel Life Ins. Co. (153 Cal. App.3d 1030; 200 Cal.Rptr. 732 [Mar. 1984] Summary Judgment § 3-Propriety. - The summary judgment procedure (Code Civ. Proc., § 437c), in as much as it denies the right of the adverse party to a trial, is drastic and should be used with caution. Summary judgment is properly granted only when the evidence in support of the moving party establishes that there is no issue of

fact to be tried. The trial court found McCormick had not identified any facts or circumstances which would constitute good cause warranting additional discovery. Since the trial court had discretion to decide this issue our review is limited to an abuse of discretion standard. We have found no such abuse and accordingly we reject this claim of error.

Disposition – The order granting the motion for summary judgment is reversed. The order denying additional discovery is affirmed. Sentinel's request for sanctions is denied and Sentinel is ordered to pay McCormick's costs on appeal. **Larraburu Brothers**, Inc., a corporation, Harold E. Paul and Harold E. Paul, Jr., Appellants, v. **Royal Indemnity Company**, a corporation, Appellee. No. 77-2229. United States Court of Appeals, Ninth Circuit. (Sept. 12, 1979)

The Ninth Circuit applies a de novo review standard to an appeal of a summary judgment. Jones v. Union Pacific R.R., 968 F.2d 937, 940 (9th Cir. 1992). In this case, the review should have been straightforward. Under Federal Rule of Civil Procedure 56(c), summary judgment is proper when there is no genuine issue as to

any material fact. Celotex Corp., 477 U.S. at 322, 106 S.Ct. at 2552, 91 L.Ed.2d at 273. Here, in this case, appellee admitted to several genuine issues as to material facts as a matter of law. Appellee admitted: (1) that it had wrongfully canceled appellant's coverage without giving notice of cancellation to appellant or the group policyholder; (2) to the denial of the payment of appellant's claims until he filed the civil action now before this Court; and (3) that its denial of coverage was erroneous, could have been disclosed by reasonable investigation. (See Appendix 4). Coverage and benefits under group health insurance plans cannot be restricted until 45 days after the insurer or plan administrator provides written notice to the group members. See Ins. C. Section 10199.1. To protect the insured's peace of mind and security, "... an insurer cannot reasonably and in good faith deny payments to its insured without thoroughly investigating the foundation for its denial." Egan v. Mutual of Omaha Ins. Co. (1979) 24 C3d 809, 819, 169 CR 691, 696 (emphasis added).

The District Court's decision was erroneous in fact and law. The law states, "absent notice to the

group members individually, the insurer continues to be bound by the coverage previously provided.

The District Court viewed appellee's belated payment of appellant's claims, after being forced to file a civil action, sufficient enough to extinguish Provident's contractual obligations.

The elements of a prima facie case for the tort of intentional infliction of emotional distress are: (1) extreme and outrageous conduct by the defendant with the intention of causing, or reckless disregard of the probability of causing, emotional distress; (2) the plaintiff's suffering severe or extreme emotional distress; and (3) actual and proximate causation of the emotional distress by the defendant's outrageous conduct. Fletcher v. Western National Life Ins. Co. (1970) 10 Cal. App. 3d 376, 394 [89 Cal. Rprt. 78, 47 A.L.R.3d 286].

The three criteria for a prima facie case for the tort of intentional infliction of emotional distress were met in this case.

Appellant was subjected to prolong intentional infliction of emotional distress, dating from December

17, 1993 to present. He has watched his customer goodwill with his dental office be destroyed by such conduct by appellee. Conduct in plain language that was "clearly frivolous, clearly vexatious, or done primarily for purposes of harassment."

First, referenced records show appellee's conduct included unsubstantiated falsehood that appellant's and dependent coverage was canceled. When in fact, appellant and his dental office has been assured by appellee's representatives between March and December of 1994, prior to his filing of this civil action, that his dependent coverage was in effect, and his coverage was never canceled. Yet, during this same period, appellee submitted false statements, reneged on over 15 to 20 phone commitments, that the problem would be taken care of by Provident, and otherwise evidenced bad faith in its dealings with appellant, on each occasion, until he filed a civil action. (See Appendix 6)

Second, appellee's memorandum in support of its motion for summary judgment, show there was a failure to investigate appellant's claim that his coverage

was not canceled by appellee, until appellant had filed the civil action now before this Court. Erroneous withholding of policy benefits resulting from failure to investigate the claim thoroughly may breach the insurer's implied covenant of good faith and fair dealing with its insured. To protect the insured's peace of mind and security, "... an insured cannot reasonably and in good faith deny payments to its insured without thoroughly investigating the foundation for its denial." Egan v. Mutual of Omaha Ins. Co. (1979) 24 C3d 809, 819, 169 CR 691, 696 (emphasis added).

Third, appellee's responses to requests for admissions, admit that appellant's coverage was never canceled (See Appendix 4). Coverage and benefits under group health insurance plans cannot be restricted until 45 days after the insurer or plan administrator provided written notice to the group members. See Ins. C. Section 10199.1. Provident, knew that no notice of cancellation of appellant's coverage had been sent out, based on: (1) the review of its own records which took place, prior to appellant's filing of a civil action, allowed its representatives to assess and make a deter-

mination from such records, that appellant's coverage was not canceled; (2) the 15 to 20 phone discussions appellant had with Provident's representatives; (3) the Los Angeles County Employees Retirement Association letter that was sent to appellant, which he in turn, informed Provident of the letter and its contends; and (4) its failure to notify appellant's employer of such cancellation. (See Appendix 8 and Ins. C. Section 12672-12675 at paragraph 6:885).

Appellant's medical records supports his claim that he suffers from extreme elevated blood pressure, associated with a sudden change of events in his daily life style, which he had identified as being a direct result of appellee's conduct, which is evidenced as stated above. Appellant's subjection to such conduct by appellee, has required him to start taking blood pressure medication again, medication he had been able to live without for the past 4 years.

On March 5, 1994, appellant was treated in the emergency room, for severe chest pain, headaches, and other symptoms, by Dr. Mason Weiss.

On October 29, 1994, appellant was admitted into the emergency room, treated by Dr. Nabil Noujaim, which his impressions were: (1) Cephalalgia/migraine type headache; and (2) Hypertension, medicated. Appellant's blood pressure was 142/112 on his arrival, but stabilized in the emergency room to 160/100, after receiving Reglan 10 mg IV and Phenergan 25 mg IV. Dr. Noujaim recommendation was that appellant be sent home to take blood pressure medicine on a regular basis. (See Appendix 10)

On January 5, 1995, appellant was treated by Dr. Roger Duber for uncontrolled hypertension, his impressions were: (1) Hypertension with associated hypertensive cardiovascular disease, inadequately controlled; (2) right carotid bruit; and (3) that arteriosclerotic heart disease cannot be ruled out definitively. Dr. Duber's recommendations were: (1) carotid ultrasound; (2) restart Norvasc 5 mg. Daily in conjunction with the Tenormin and Dyazide for appropriate antihypertensive therapy; and (3) Aspirin 81 mg. Daily. (See Appendix 11)

On October 3, 1995, appellant was given a physical examination by Frank J.Y. Hsu. Dr. Hsu's impres-

sion was hypertension, and put back on blood pressure medication, namely, Norvasc 5 mg. Daily, Atenolol 50 mg. Daily, and Diazide 1 mg. Daily. (See Appendix 10)

On December 6, 1995, appellant was treated by Psychologist Richard K. Smith for emotional discord and disturbance and it represents a significant psycho-social stressor. (See Appendix 10)

Appellant's present medical condition started when he was forced to prove that his dependent was a full time student, before appellee would honor his dependent claims, although, appellee was still collecting its premium, had failed to give a 45 day notice of changes in coverage, as required by law. (See Appendix 11) Whereas, the Ins. Code states, "absent notice to the group members individually, the insurer continues to be bound by the coverage previously provided."

Appellant's dependent claims were denied until appellant filed a small claim against appellee, immediately appellee declared they had received the proof and that appellant's dependent claims would be honored. (See Appendix 6)

In Nationwide Mutual, the insured brought action against disability income insurer for bad-faith denial of coverage and for breach of contract. The Court direct a verdict for insured on contract count and entered a judgment that the insurer was acting in bad-faith in refusing to pay the insured medical claim and granted petition for writ of certiorari. In both cases the verdict shows that the insurer's was acting in bad-faith for not paying insured's claims therefore putting both insured's in fear that their medical bills would not be paid therefore causing them to suffer extreme emotional distress, and mental distress. Nationwide Mutual Insurance Company v. Henry Garrad Clay. 82-536, 82-917, Cite as 525 So. 2d Pg 1339 (Ala 1987), 525 Southern Reporter, 2d Series.

In McCormick, the court of appeals held that a finding of bad faith is not negated simply because the insurer never formally denies benefits, because in many cases a lengthy delay in resolving a claim for insurance benefits has the identical consequences for the insured as an outright denial of benefits. See McCormick v. Sentinel Life Ins. Co. (1984) 153 Cal App3d 1030, 200

Cal Rptr 732. Here, appellee simply outright denied benefits, after being repeatedly told by appellant, that his coverage was not canceled, if so, why did he not receive a notice of cancellation as required by law. Absent notice to the group members individually, the insurer continues to be bound by the coverage previously provided. Tenzer v. Super Scope Inc. Cite AS 216 Cal Rptr 130 (Cal. 1985). Fact – Board member brought action against his corporation alleging that he was entitled to payment of a Real Estate commission for finding a purchaser for corporation's property. The Superior Court, Los Angeles County, Sara Kleban Radin, J., granted corporation's motion for summary Judgment and appeal was taken. The Supreme Court, Grodin, J., held that (1) there is no finder's fee exception to the statute of frauds. (2) Board member, as Real Estate Finder, was not precluded from invoking doctrine of Estoppel to plead statute of Frauds. (3) Whether board member acted as broker was a question of fact, precluding summary Judgment. (4) Whether board member's agreement with corporation was fair and reasonable was a question of fact, Procluding Summary Judgment Reversed.

Conclusion – Resolution of this issue requires information which at this point, does not appear in the record. For this reason, we conclude that Summary Adjudication was inappropriate. The Judgment is Reversed.

Because, appellant "was compelled" to file this civil action before appellee offered to pay appellant's claims. Because, he was compelled to file this civil action, there is a causal connection between appellant's actions and appellee's conduct. Thus, there are damages as a matter of law for breach of contract. The purpose of first party coverage is to indemnify the insured for covered losses. Thus, in first party cases, the implied covenant of good faith and fair dealing obligates the insurance company not to "unreasonably" withhold benefits. If the insurer refuses to pay what is due under the contract "without proper cause," its conduct is actionable as a tort. Gruenberg v. Aetna Ins. Co. (1973) 9 C3d 566, 573, 108 CR 480, 485. "For the insurer to fulfill its obligation ... it again must give at least as much consideration to the latter's interest as it does to its own." Egan v. Mutual of Omaha Ins. Co. (1979) 24 C3d 809, 8180819, 169 CR 691, 695.

Here, the insurer filed to fulfill its obligation to appellant on two separate, but equal occasions. In December 1993, appellee denied appellant's dependent claims until he was compelled to file a claim with the Small Claims Court. Yet, immediately upon appellant's filing of referenced claim with the Small Claims Court (same as in the instance case), within less than two days appellee was able to take care of its obligation. Whereas, appellant had hassled with appellee for practically four months. Although, appellee knew it was wrongfully denying appellant's dependent coverage, because there had been no notice of cancellation or change in coverage ever sent to appellant, as required by law. Yet, the hassle continued until appellant filed said claim. The same set of circumstances exist in the instance case, prolong hassle for the payment of benefits, again appellee knew there had been no notice of cancellation or change in coverage that was ever sent to appellant, as required by law. Therefore, unless appellant receives assistance from the court, appellee will continue this pattern, of collecting premiums and hassling the insured for the payment of their benefits.

Appellee could only muster, in defense of such conduct, that such continuous and prolong bad faith conduct was due to a clerical error. When appellee's memorandum in support of its motion for summary judgment, show there was a failure to investigate appellant's claim that his coverage was not canceled by appellee. Whereas, erroneous withholding of policy benefits resulting from failure to investigate the claim thoroughly may breach the insurer's implied covenant of good faith and fair dealing with its insured. To protect the insured's peace of mind and security, "... an insurer cannot reasonably and in good faith deny payments to its insured without thoroughly investigating the foundation for its denial." Egan v. Mutual of Omaha Ins. Co. (1975) 24 C3d 809, 819, 169 CR 691, 696 (emphasis added). Therefore, appellee's denial of benefits without "proper cause" is a breach of contract.

In Comunale, the court stated that: "(T)he implied obligation of good faith and fair dealing requires the insurer to settle in an appropriate case although the express terms of the policy do not impose such a duty." Comunale v. Traders & General Ins. Co., supra, 50 C2d

at 658, 659, 663, 328 P2d at 200, 201, 203.

In Crisci v. Security Ins. Co. (1967) 66 C2d 425, 58 CR 13, the court relied on the dictum in Comunale, above, to impose tort liability for emotional distress and financial losses resulting from wrongful refusal to settle a liability claim against the insured "within the policy limits." The implied covenant of good faith and fair dealing was thus recognized as the source of tort duties. Crisci v. Security Ins. Co., supra, 66 C3d at 429-430, 58 CR at 16-17.

Under this "well-developed judicial history," an insurer's breach of the implied covenant of good faith and fair dealing gives rise to both contract and remedies: i.e., in addition to whatever is due under the insurance policy (contract damages), the insurer may be liable for all damages proximately resulting from its breach (tort damages) ... including emotional distress, economic losses and certain attorney fees, and, if the requirements of Civ. C. Section 3294(a) are satisfied, punitive damages as well. Gruenberg v. Aetna Ins. Co. (1973) 9 C3d 566, 574, 108 CR 480, 485. An insurer is said to act in "bad faith" when it breaches its duty to deal "fairly" and

in "good faith" with its insured. Neal v. Farmers Ins. Exch. (1978) 21 C3d 910, 921, 148 CR 389, 395, fn. 5.

Here, the only question before the court, is whether the "purported clerical error" was "reasonable" as a matter of law? Appellant contends the "purported clerical error" is nothing but appellee's last line of defense for its "unreasonable acts of bad faith."

"Bad Faith" exists where an insurer denies a claim on the ground that coverage had terminated before the claim arose. If the insurer's position is both incorrect (e.g., cancellation ineffective because of inadequate notice) and "unreasonable" (e.g., no attempt to verify cancellation), a "bad faith" action may be pursued against the insurer. Coverage and benefits under group health insurance plans cannot be restricted until 45 days after the insurer or plan administrator provides written notice to the group members. See Ins. C. Section 10199.1. Absent notice to the group members individually, the insurer continues to be bound by the coverage previously provided. Fields v. Blue Shield of Calif. (1985) 163 CA3d 570, 579, 209 CR 781, 785-786. Cancellation provisions, like other pro-

visions of the insurance contract, are subject to the implied covenant of good faith and fair dealing and cannot be used to deprive the insured of the benefit of his or her bargain. Spindle v. Travelers Ins. Co. (1977) 66 CA3d 951, 9580959, 136 CR 404, 408.

Even if Provident did ultimately offer to settle appellant's claim, it was done after appellant had incurred excess damages and filed the civil action now before the court. Appellee's unreasonable conduct, before it made the offer to pay claims, was a proximate cause of recoverable damages to the insured. For example, appellee's unreasonable delay in offering to pay claims injured appellant financially, mentally, and destroyed his customer goodwill. Bodenhamer v. Sup. Ct. (St. Paul Fire & Marine) (1987) 192 CA3d 1472, 1478-1479, 238 CR 177, 180-181; Larraburu Bros., Inc. v. Royal Indem. Co. (9th Cir. 1979) 604 F2d 1208, 1215, discussed at paragraph 12:272.

"Unreasonableness" is generally equated with "lack of proper cause" for withholding benefits. However, in the case now before this Court, appellee's "negligence" constitutes the ultimate of "unreasonable-

ness" because it was negligent in investigating and evaluating the claims it denied. Erroneous withholding of policy benefits resulting from failure to investigate the claim thoroughly may breach the insurer's implied covenant of good faith and fair dealing with its insured. To protect the insured's peace of mind and security, "... an insurer cannot reasonably and in good faith deny payments to its insured without thoroughly investigating the foundation for its denial." Egan v. Mutual of Omaha Ins. Co. (1979) 24 C3d 809, 819, 169 CR 691, 696 (emphasis added). The insurer's duty to investigate "thoroughly" arises out of its implied covenant of good faith and fair dealing with the insured: "For the insurer to fulfill its obligation not to impair the right of the insured to receive the benefits of the agreement... it is essential that an insurer fully inquire into possible bases that might support the insured's claim." Egan v. Mutual of Omaha Ins. Co., supra, 24 C3d at 819, 169 CR at 695 (emphasis added); Hughes v. Blue Cross of No. Calif. (1989) 215 CA3d 832, 846, 263 CR 850, 857. Where a duty to investigate has arisen (below), the insurer's failure to investi-

gate properly breaches its implied covenant as a matter of law. See Egan v. Mutual of Omaha, supra, 24 C3d at 817, 169 CR at 695; and Frommoethelydo v. Fire Ins. Exchange (1986) 42 C3d 208, 220, 228 CR 160, 167.

"If an insurance company could deny a claim without thoroughly investigating it and then defend a subsequent lawsuit on grounds which it develops during discovery for trial, the company's incentive to investigate would be significantly diminished." McLaughlin v. Connecticut Gen. Life Ins. Co. (ND CA 1983) 565 F. Supp. 434, 451 (applying Calif. Law).

An insurer that refuses to pay a claim or accept a reasonable settlement offer of the claim, in violation of its duty to consider in good faith the interest of the insured in the settlement of a claim, is liable for the injury to the insured right to receive the benefit of the insurance policy. Johansen v. California State Auto. Ass'n Inter-Ins. Bureau (1975) 15 Cal. 3d 9, 14-16, 123 Cal Rptr. 288, 538 P.2d 744; Comunale v. Trader & General Ins. Co. (1958) 50 Cal 2d 654, 659, 328 P. 2d 1989; Brown v. Guarantee Ins. Co. (1957) 155 Cal App2d 679, 682, 319 P2d 69.

The insurer's duty of good faith and fair dealing is unconditional independent of the performance of the insured's contractual obligations. Gruenberg v. Aetna Ins. Co. (1973) 9 Cal 3d 566, 578, 108 Cal Rptr 480, 510 P2d 1032.

In Johansen, the Supreme Court, said that California authorities establish that an insurer who fails to accept a reasonable settlement offer to resolve a claim against the insured, that is within the policy limits, because it believes the policy has been terminated, assumes the risk that it will be held liable for all damages resulting from such refusal, including damages in excess of applicable policy limits. In addition, the court said, an insurer who denied coverage does so at its own risk, and that if the denial is found to be wrongful, it is liable for the full amount which compensate the insured for all the detriment caused by the insurer's breach of the express and implied obligation of the contract.

In Garner, the court said that the insurer is required to concern itself with the interests and welfare of the insured as well as its own interest and welfare, and in so doing must carefully and realistically assess the claim against the insured as to the issue of liability

and as to the potential magnitude of possible damage to determine the financial risk to each party resulting from failure to settle or attempt to settle a claim. The court said that if an insurer undertakes to carry out its duty to the insured, it is a factual question whether or not the insurer has acted in good faith and made a reasonable effort on behalf of the insured to settle a claim. Garner v. American Mut. Liab. Ins. Co. (1973) 31 Cal App3d 843, 107 Cal Rptr 604.

The Supreme Court, quoting from Comunale v. Traders & General Ins. Co. (1954) 50 Cal 2d 654, 660, 328 P2d 198, said that an insurer who denies coverage does so at its own risk. Although its position may not have been entirely groundless, if the denial is found to be wrongful, the insurer is liable for the full amount which will compensate the insured for all the detriment caused by the insurer's breach of the express and implied obligation of the contract. The Court concluded that, accordingly, contrary to defendant's suggestion, an insurer's "good faith," though erroneous, belief in NON-COVERAGE affords no defense to liability flowing from the insurer's refusal to accept a rea-

sonable claim. See Johansen v. California State Auto. Ass'n Inter-Ins. Bureau (1975) 15 Cal 3d 9, 16, 123 Cal Rptr 288, 538 P2d 744.

In Anderson, the insured sought to recover against insurer and other for bad-faith refusal to honor and pay a claim under homeowners policy. The Court held that a cause of action in tort against an insurer for bad-faith refusal to honor a claim of insured may be pleaded and, under appropriate facts, may be proved and damages may be afford. The Complaint alleging that insurer and other defendants acted in b ad-faith intentionally and maliciously for purpose of harassing plaintiff insured to discourage them from asserting their rightful claim under homeowners policy and prevent them from collecting amount due under the policy.

CONCLUSION

The purpose of insurance is to protect the insured. Thus, the implied covenant of good faith and fair dealing obligates an insurer to accept, on a timely basis, claims within the policy limits, in order to avoid exposing its insured to the risk of excess liability. If insurer unreasonably refuses to settle, "simple justice" demands that it absorb the losses resulting from such refusal. Gruenberg v. Aetna Ins. Co. (1979) 9 C3d 566, 573, 108 CR 480, 485. Even if the insurer ultimately settles the claim, so that there is no excess liability, the insurer's unreasonable conduct before settlement can still be a proximate cause of recoverable damages to the insured. For example, the insurer's unreasonable delay in settling claim may injure the insured financially and destroy customer goodwill. See Bodenhamer v. Sup. Ct. (St. Paul Fire & Marine) (1987) 192 CA3d 1472, 1478-1479, 238 CR 177, 180-181; Larraburu Bros., Inc. v. Royal Indem. Co. (9th Cir. 1979) 604 F2d 1208, 1215, discussed at paragraph 12:572. Because, appellant "was compelled" to file

this civil action before appellee offered to pay appellant's claims, because appellee's denial of benefits was without good cause, constitutes an act of bad faith.

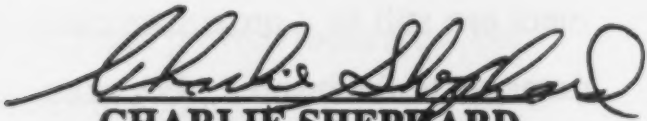
For all of the foregoing reasons, Appellant prays:

(a) For this Court to reverse the lower Court's Judgments and Orders on all issues presented on appeal, remand the case back to the District Court for trial;

(b) For all causes of action, such other relief as the Court deems proper.

Dated: December___, 1997.

Respectfully submitted,



CHARLIE SHEPHARD,
Appellant in Pro Se

LIST OF APPENDIX

1. Decision issued on June 19, 1996 in Charlie Shephard vs. Provident Life & Accident Insurance Co., No. 95-56664 in the United States Court of Appeals for the Ninth Circuit.
2. Order denying Petition for Rehearing issued on June 10, 1997, in Charlie Shephard vs. Provident Life & Accident Insurance Co., No. 95-56664 in the United States Court of Appeals for the Ninth Circuit.
3. Final Order issued by Judge George H. King on October 20, 1995, Charlie Shephard vs. Provident Life & Accident Insurance Co., Civil Action No. CV 95-0493 GHK (EX) in the United States District Court for the Southern District of California, Los Angeles Division.
4. Defendant's Admissions that it had wrongfully canceled appellant's coverage without giving notice of cancellation to appellant or the group policyholder.
5. Letter from plaintiff's dental office stating his dependent was covered under his policy and inforce.

6. Plaintiff's filing of small claim to get defendant to honor policy and the start of its continuous acts of bad faith.
7. Letter from policyholder stating plaintiff's coverage has never been canceled and copies of premium payments deducted from plaintiff's pay.
8. Appellant's proof of additional emergency room treatment as a result of defendant's continuous acts of bad faith.
9. Appellant's proof of medical treatment for uncontrolled hypertension as a result of defendant's continuous acts of bad faith.
10. Appellant's additional proof of continuos uncontrolled hypertension as a result of defendant's continuous acts of bad faith.
10. Appellant's proof that his dependent was a full time student.